Screening Questionnaire for Inactivated Injectable Influenza Vaccine 2021-2022

ONTARIO PHARMACISTS ASSOCIATION
Advocating Excellence in Practice and Care

Section 1: Personal Information

Patient First and Last Name:		Patient Telephone:	
Patient Address:		Patient OHIP No. (if applicable):	
☐ Male ☐ Female	Age:	Child's Weight: kg OR lb	Date of Birth (MM/DD/YYYY)
Name of Emergency Contact:		Contact's Daytime Phone Number:	
Emergency Contact's Relationship to Patient:		Contact's Evening/Other Phone Number:	

COVID-19 Vaccination Status
☐ Received all required doses >14 days ago ☐ Unimmunized/partially immunized/≤14 days after final dose ☐ Undisclosed

Section 2: COVID-19 Screening

Note: Every individual who will be present during the administration of the vaccine (regardless of whether you are receiving a vaccine or not) should be screened for COVID-19.

Are you experiencing any of the following symptoms?
(If you received a COVID-19 vaccination in the last 48 hours and are experiencing mild fatigue, muscle aches and/or joint pain that only began after vaccination, select "No.")

- Fever and/or chills
- New onset of cough or worsening chronic cough
- Shortness of breath
- Decrease or loss of smell or taste
- Fatigue, lethargy, malaise and/or muscle aches (myalgias) (for adults ≥18 years of age)
- Nausea, vomiting and/or diarrhea (for children <18 years of age)

☐ Yes ☐ No

In the last 10 days, have you tested positive for COVID-19 or have been told that you should be isolating?
☐ Yes ☐ No

If you are <u>not</u> fully vaccinated*, please also answer the following two questions.
* A fully vaccinated individual is defined as any individual >14 days after receiving their second dose of a two-dose COVID-19 vaccine series or their first dose of a one-dose COVID-19 vaccine series (i.e., Johnson and Johnson).

Did you travel outside of Canada in the past 14 days?
☐ Yes ☐ No

Have you had close contact with a confirmed case of COVID-19 without wearing appropriate PPE?
☐ Yes ☐ No

If you respond YES to **ANY** of the screening questions in Section 2, you should not receive a flu shot at the pharmacy at this time and should speak with your pharmacist.

If the responses to **ALL** of the screening questions in Section 2 are **NO,** proceed to Section 3.

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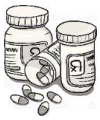

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Section 3: Screening Questionnaire

For adult patients as well as parents of children (≥ 2 years of age) to be vaccinated:

The following questions will help us determine if there is any reason you or your child should not get the flu shot today. If you answer "yes" to any question, it does not necessarily mean the shot cannot be given. It simply means additional questions must be asked.

If a question is not clear, please ask your pharmacist to explain it.

Please answer the following questions	Yes	No	Unsure	Action required
Are you **sick today**? (fever greater than 39.5ºC, breathing problems, or active infection)	☐	☐	☐	If YES, do NOT get the shot today
Do you have any **allergies** that you are aware of?	☐	☐	☐	If YES, list what you are allergic to here:
Are you **allergic** to any of the following? Check all that apply: ☐ Thimerosal ☐ Egg/egg protein/chicken protein ☐ Kanamycin, neomycin, polymyxin B ☐ Formaldehyde ☐ Sodium Deoxycholate ☐ Triton® X-100 ☐ Hydrocortisone ☐ Cetyltrimethylammonium bromide (CTAB) ☐ Polysorbate 80	☐	☐	☐	If YES, your pharmacist can check whether the flu shot contains any of these potential allergens and use one which does not. (If you have an allergy or reaction to egg/egg protein/chicken protein, speak to the pharmacist. You may be able to receive the flu shot but may require a longer observation period post-administration.)
Are you **allergic** to any part of the flu shot, or have you had a severe, life-threatening allergic reaction to a past flu shot?	☐	☐	☐	If YES or UNSURE, do NOT get the shot & SPEAK WITH YOUR MD
Have you had **wheezing, chest tightness or difficulty breathing** within 24 hours of getting a flu shot?	☐	☐	☐	
Do you have any **serious allergy** to latex or natural rubber?	☐	☐	☐	If YES or UNSURE, you can receive the flu shot but non-latex materials are to be used
Have you had **Guillain-Barré Syndrome** within 6 weeks of getting a flu shot?	☐	☐	☐	If YES, do not get the flu shot and SPEAK WITH YOUR MD
Do you have a **new or changing** neurological disorder?	☐	☐	☐	If YES, do not get the flu shot & SPEAK WITH YOUR MD
Do you have **bleeding problems or use blood thinners**? (e.g., warfarin, low dose or regular strength aspirin)	☐	☐	☐	If YES, you can get the flu shot but apply gentle pressure afterwards

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Section 4: Consent Given By Patient/Agent

I, the client, parent or guardian, have read or had explained to me information about the flu shot as outlined on the Flu Shot Fact Sheet. I have had the chance to ask questions, and answers were given to my satisfaction. I understand the risks and benefits of receiving the flu shot. I agree to wait in the pharmacy for 15 minutes (or time recommended by the pharmacist) after getting the flu shot.

I am aware that it is possible (yet rare) to have an extreme allergic reaction to any component of the vaccine. Some serious reactions called "anaphylaxis" can be life-threatening and are deemed medical emergencies. If I experience such a reaction following vaccination, I am aware that it may require the administration of epinephrine, diphenhydramine, beta-agonists, and/or antihistamines to try to treat this reaction and that 911 will be called to provide additional assistance to the immunizer. The symptoms of an anaphylactic reaction may include hives, difficulty breathing, swelling of the tongue, throat, and/or lips. In the event of anaphylaxis, I will receive a copy of this form containing information on emergency treatments that I had received, or a copy will be provided to my agent or EMS paramedics.

☐ **I confirm that I want to receive the seasonal influenza vaccine** **OR** ☐ **I confirm that I want my child 2 years of age or older to receive the seasonal influenza vaccine**

Patient/Agent Name (& Relationship)	**Patient/Agent Signature**	**Date Signed** (MM/DD/YYYY)

PHARMACIST DECLARATION: I confirm the above named patient/agent is capable of providing consent, and if written/electronic consent cannot be obtained, the patient/agent has provided verbal consent for the administration of the seasonal influenza vaccine to the patient. Based on my professional judgement, seasonal influenza vaccine should be administered to the patient.

Pharmacist Signature	**OCP License #**	**Date Signed** (MM/DD/YYYY)

Section 5: Prescription Templates – Pharmacy Use Only

INFLUENZA VACCINE

Patient Name:

☐ FLULAVAL TETRA – DIN 02420783 – QIV
15 mcg/0.5 mL – 5 mL (multi-dose) vial **(age 2 or older)**

☐ FLUZONE® QUADRIVALENT – DIN 02432730 – QIV
15 mcg/0.5 mL – 5 mL (multi-dose) vial **(age 2 or older)**

☐ FLUZONE® QUADRIVALENT – DIN 02420643 – QIV
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 2 or older)**

☐ AFLURIA® TETRA – DIN 02473313 – QIV
15 mcg/0.5 mL – 5 mL (multi-dose) vial **(age 5 or older)**

☐ AFLURIA® TETRA – DIN 02473283 – QIV
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 5 or older)**

☐ FLUCELVAX® QUAD – DIN 02494248 – QIV
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 2 or older)**

☐ FLUZONE® HIGH-DOSE QUADRIVALENT – DIN 02500523 – QIV-HD
60 mcg/0.7 mL – 0.7 mL (single-dose) syringe **(age 65 or older)**

☐ FLUAD®– DIN 02362384 – TIV-adj
15 mcg/0.5 mL – 0.5 mL (single-dose) syringe **(age 65 or older)**

Vaccine Lot #:	Expiry (MM/YYYY):
Date and Time of Immunization:	Location of Immunization: ☐ Pharmacy ☐ Other:

Dose	Route	Site of administration
mL	**IM**	☐ Left: ☐ Right:

Administering Pharmacist Name and OCP #:

Administering Pharmacist Signature:

EPINEPHRINE EMERGENCY TREATMENT

Patient Name:

☐ EpiPen® 0.3 mg/0.3 mL
DIN 00509558 – **Note: Use the *PIN 09857423* for EpiPen 0.3 mg/0.3 mL claims for adverse events within the UIIP**

☐ EpiPen Junior® 0.15 mg/0.3 mL
DIN 00578657 – **Note: Use the *PIN 09857424* for all EpiPen Junior 0.15 mg/0.3 mL claims for adverse events within the UIIP**

☐ Allerject® 0.3 mg/0.3 mL
DIN 02382067 – **Note: Use the *PIN 09857440* for Allerject 0.3 mg/0.3 mL claims for adverse events within the UIIP**

☐ Allerject® 0.15 mg/0.15 mL
DIN 02382059 – **Note: Use the *PIN 09857439* for Allerject 0.15 mg/0.15 mL claims for adverse events within the UIIP**

☐ Emerade™ 0.5 mg/0.5 mL
DIN 02458454 – **Note: Use the *PIN* 09858130 for Emerade 0.5 mg/0.5 mL claims for adverse events within the UIIP**

☐ Emerade™ 0.3 mg/0.3 mL
DIN 02458446 – **Note: Use the *PIN* 09858129 for Emerade 0.3 mg/0.3 mL claims for adverse events within the UIIP**

Number of Doses Administered:

Date of Administration:	Time(s) of Administration: 1. 2. *(if applicable)* 3. *(if applicable)*
Administering Pharmacist Name and OCP #:	Administering Pharmacist Signature:

Additional Notes (including other emergency measures taken or treatments administered):

Date & Time of Follow-up with Patient/Agent: